KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Coordination of Benefits				POLICY #: 6.08-P	
DEPARTMENT: Claims					
Effective Date: 10/2000	Review/Revised Date: 12/20/2016	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 12/20/16

Chief Financial Officer — Date 12/20/16

Chief Operating Officer — Date 10/13/16

Administrative Director of Health Services — Date 10/6/16

Director of Claims — Date 9/30/16

POLICY:
The Kern Health Systems (KHS) Claims Department will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Kern Health Systems Claims Department will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

PROCEDURES:

1.0 IDENTIFICATION OF OTHER INSURANCE

The Kern Health Systems Claims Department identifies members that are covered under any other program using the following sources:

A. Enrollment information received from the Department of Health Care Services

(DHCS)

B. Information received from the Provider on the claim form or during the authorization process
C. Information received from the member
D. Receipt of reimbursement from provider

KHS personnel document the other coverage information in the member's eligibility file in the KHS information system. Claims staff use this file in claims processing to identify other insurance coverage.

2.0 REIMBURSEMENT

If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment to a provider for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

KHS will adopt the Medicare allowable and pay full coinsurance and deductible for Long Term Care and Dialysis services. KHS may adopt the Medicare allowable in other cases when there is no established allowable found under Medi-Cal such as newly established codes not yet adopted by Medi-Cal. KHS will also adopt the Medicare allowable when it is lower that the contracted rate determined for the claim payment as a whole.

2.1 Utilization Management Review Requirements

If Kern Health Systems' liability is zero after the primary carrier has made payment, it is not necessary to refer claims to Utilization Management for authorization. However, if there is a payment due on a claim, an authorization is necessary for services that require Authorization.

The Utilization Management Department conducts pre-certification and concurrence review for all KHS Plan member hospitalizations regardless of the existence of other coverage including Medicare.

3.0 COST AVOIDANCE

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the provider has first exhausted all other sources of payment.

An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to plan members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by Kern Health Systems.

4.0 POST-PAYMENT RECOVERY

4.1 Situations which Require Post-Payment Recovery

KHS pays the provider's claim and seeks to recover the cost of the claim from the third party in the following circumstances:

A. For services provided to Medi-Cal Members with OHC codes A, M, X, Y, OR Z

B. For Medi-Cal services defined by DHCS as prenatal or preventive pediatric services

C. In child-support enforcement cases, identifiable by KHS. If sufficient information is not available to determine whether or not the OHC coverage is the result of a child support enforcement case, KHS follows the procedures for Cost Avoidance.

4.2 Identification of Other Insurance Coverage after Initial Payment

If a payment was made prior to identifying another Plan, the Claims Department seeks reimbursement from the provider or other Plan.

5.0 CLAIMS PAYMENT WITH OTHER INSURANCE

Whenever a claim is received and other insurance is indicated the following steps are taken:

A. If the claim is received without an Explanation of Benefits (EOB) from the third party, the claim is denied (except for services and OHC codes listed above in Post-Payment Recovery guidelines).

B. If the claim is received and an EOB is attached from the third party, the following steps are taken to adjudicate the claim:

(i) If the provider accepts the OHC payment as "payment in full" KHS does not pay the balance of the provider's bill.

(ii) If a claim is received from a member who has other coverage through an HMO or PPO and charges were denied because a contracting provider or facility within their network was not used, the claim is denied.

(iii) If the provider accepts the OHC payment as "payment in full" and the entire OHC allowable amount was applied to the deductible, the lesser of the allowable amounts between KHS and the OHC is used to determine payment. Payment is calculated based on the lesser of the allowed amounts minus any applicable withhold. With the exceptions of Long Term Care and Dialysis, this is true for Medicare, when they accept payment in full, as well as any other OHC who accepts payment in full.

(iv) If the EOB indicates the member is responsible for the balance of the allowable amount, payment is based on KHS' allowable amount minus any amount paid by the OHC (COB amount). If the EOB attached

indicates that the total allowed charges was applied to the member's OHC deductible, Kern Family Health Care pays the claim based on KHS' allowable amount minus any applicable withhold.

(v) If the OHC has denied payment, an EOB with the explanation must be submitted. If the service is a KHS covered procedure, payment is made based on KHS' allowable amount withhold. If the OHC has denied payment pending additional information, no payment is issued by KHS until a final denial has been indicated on the EOB.

6.0 REPORTING REQUIREMENTS

6.1 Medi-Cal Product

KHS submits weekly reports to DHCS of Other Health Coverage change request which include Modification, Termination and Addition of OHC. Reports are sent in a format prescribed by DHCS electronically using OCU HI-36 Transaction file to DHCS SFTP site. (See Attachment A).

6.2 Third Party Liability

When KHS identifies OHC unknown to DHCS for Third Party Liability for possible accidents and/or injuries, KHS reports this information to DHCS within ten (10) days of discovery in an automated format as prescribed by DHCS. Information is submitted electronically to:

http;//www.dhcs.ca.gov/services/pages/TPLRD_PI_OnlineForms/aspx
(See Attachment B).

ATTACHMENTS:

- Attachment A: Other Health Coverage Change Request
- Attachment B: Managed Care Report
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REFERENCE:

Revision 2016-09: Policy revised by Director of Claims to remove MHC language from policy due to new core system. Section for disenrollment removed based on OHC codes. **Revision 2014-03:** Revisions made in section 2.0 "Reimbursement" as requested by the Director of Claims. Removed references to Healthy Families. **Revision 2012-12:** Policy updated by Director of Claims and Claims Supervisor. Includes changes to reporting processes and updated attachments.

BENEFICIARY INFORMATION					INSURANCE CARRIER INFORMATION							POLICY HOLDER INFORMATION			POLICY INFORMATION			SCOPE OF COVERAGE								
Medi-Cal Client Index No. (CIN#) 9 digits	Date of Birth 8 digits	Last Name 20 digits	First Name 15 digits	Middle Initial 1 digit	Carrier Code 4 digits	Carrier Name 30 digits	Address Line 1 50 digits	City 25 digits	State 2 digits	Zip 5 digits	Zip Plus 4 4 digits	Last Name 20 digits	First Name 15 digits	Middle Initial 1 digit	Policy Number 30 digits	Effective Start Date 8 digits	End Date 8 digits	Out-patient Valid Value "O"	In-patient Valid Value "I"	Physicians Valid Value "M"	LTC Valid Value "L"	Pharmacy Valid Value "P"	Dental Valid Value "D"	Vision Valid Value "V"	

Managed Care Report

Entry Date From 5/1/12 Entry Date to 5/15/12

MCP Number	CIN Number	Last Name	First Name	Date Of Birth	Service From	Service To	Request
201 - Managed Care Name	cXXXXXXXXX	Test	Test	12/12/2011	12/31/2011	5/14/2012	2nd Request
201 - Managed Care Name	cXXXXXXXXX	Test	Test	8/1/2011	8/15/2011	5/14/2012	3rd Request
201 - Managed Care Name	cXXXXXXX	Test	Test	10/19/2011	10/19/2011	5/14/2012	1st Request